Harris County: Aetna Base PLUS Plan: Point of Service II Coverage Period: 03/01/2014 – 2/28/2015

Summary of Benefits & Coverage: What this Plan Covers & What it Costs **Coverage for:** Employee+Dependents | **Plan Type:** POS

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.harriscountytx.gov/hrrm/ or by calling (713) 274-5500 or toll free (866) 474-7475.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: None Out-of-network: $1,000 person/$3,000 family	You don't have to meet **deductible** for specific services, but see the chart on page 2 for other costs for services this plan covers.
Are there other Deductibles (DED) for specific services?	Yes, a $250 DED for in network hospice services.	There are no other specific deductibles.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers **$5,600** person / **$11,200** family For non-participating providers **$9,000** person / **$27,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. All copays apply to out-of-pocket maximums.
What is not included in the out–of–pocket limit?	Health care this plan doesn't cover and prescription drugs.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for ***specific*** covered services, such as office visits. There is an out-of-network lifetime limit of $1,000,000.
Does this plan use a network of providers?	Yes. See www.aetna.com **or call 1-800-279-2401** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

- **Co-payments** are fixed dollar amounts (for example, $25) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-network	Out-of-network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	40% after DED	Deductible applies to out-of-network.
	Specialist visit (Aexcel/Non-Aexcel)	$30/40 copay/visit	40% after DED	If you obtain services from one of the ten Aexcel specialty categories listed in the Resource Guide and see an Aexcel designated physician, OR if you obtain specialty services that are not one of the ten Aexcel specialty categories (for example: dermatology) your copay will be $40.
	Chiropractor	$30 copay per visit	40% after DED	Limited to $600 per calendar year
	Preventive care/screening/immunization	No charge for 1 visit per year	40% after DED	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources & Services Administration.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% after DED	Deductible applies to out-of-network.
	Imaging (CT/PET scans, MRIs)	$100 copay	40% after DED	Precertification required.

Common Medical Event	Services You May Need	Your cost if you use a In-network	Your cost if you use a Out-of-network	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.hctx.net/cmpdocuments/63/doc/2012summaryplandocuments.pdf	Generic drugs – retail copay Generic drugs – mail order copay	$5 min/$35 max $10 min/$70 max or 25% of the negotiated charge	40% co-insurance	Retail covers up to a 30-day supply; mail order is a 31-90 day supply
	Brand drugs – retail copay Brand drugs – mail order copay	$25 min/$100 max $50 min/$200 max or 30% of the negotiated charge	40% co-insurance	Retail covers up to a 30-day supply; mail order is a 31-90 day supply
	Specialty drugs	$50 min/$200 max or 30% of the negotiated charge	40% co-insurance	Specialty drugs and blood clotting factor must be obtained within the Aetna specialty pharmacy network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 copay/visit	40% co-insurance	Deductible applies to out-of-network.
	Physician/surgeon fees	100% coverage	40% co-insurance	Deductible applies to out-of-network.
If you need immediate medical attention	Emergency room services	$300 copay/visit	$300 copay/visit	Waived if admitted
	Emergency medical transportation	100% coverage	100% coverage	----------none----------
	Urgent care	$50 copay/visit	40% co-insurance	Deductible applies to out-of-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/visit	40% co-insurance	Deductible applies to out-of-network.
	Physician/surgeon fee	100% coverage	40% co-insurance	Deductible applies to out-of-network.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-network	Out-of-network	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay/visit	40% co-insurance	Deductible applies to out-of-network
	Mental/Behavioral health inpatient services	$500 copay/visit	40% co-insurance	Deductible applies to out-of-network
	Substance use disorder outpatient services	$40 copay/visit	40% co-insurance	Deductible applies to out-of-network
	Substance use disorder inpatient services	$500 copay/visit	40% co-insurance	Deductible applies to out-of-network
If you are pregnant	Prenatal and postnatal care	100% covered	40% co-insurance	Copay varies whether Aexce/Non-Aexcel provider is utilized. Deductible applies to out-of-network.
	Delivery and all inpatient services	$500 copay for mom & each baby	40% co-insurance	Deductible applies to out-of-network

Common Medical Event	Services You May Need	Your cost if you use a In-network	Your cost if you use a Out-of-network	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	100% coverage	40% co-insurance	Limit of 100 visits per calendar year. Deductible applies to out-of-network
	Rehabilitation services	$20 copay/visit	40% co-insurance	Limit of 60 visits per calendar year, deductible applies to out-of-network
	Habilitation services	Not covered	Not covered	Some of these benefits may be covered under rehabilitation services and are subject to precertification.
	Skilled nursing care	100% coverage	40% co-insurance	Limit of 100 days per calendar year, deductible applies to out-of-network.
	Durable medical equipment	100% coverage	40% co-insurance	Deductible applies to out-of-network
	Hospice service	10% after $250 deductible	40% co-insurance	Deductible applies to in and out-of-network
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Optical care covered under the vision plan.
	Glasses	Not Covered	Not Covered	Limited glasses benefit provided on the vision plan.
	Dental check-up	Not Covered	Not Covered	Dental services covered under the dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Hearing aids-$1,500 maximum every 36 months
- Private-duty nursing
- Routine foot care (non-cosmetic)
- Weight loss programs (with limitations)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (713) 274-5500 or toll free at (866) 474-7475. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Aetna at (713) 274-5500 or toll free at (800) 279-2401.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,503
- **Plan pays** $6,463
- **Patient pays** $1,040

Sample care costs:

Hospital charges (mother)	$3,999
Routine obstetric care	$1,250
Hospital charges (baby)	$782
Anesthesia	$875
Laboratory tests	$175
Prescriptions	$145
Radiology	$250
Vaccines, other preventive	$27
Total	**$7,503**

Patient pays:

Deductibles	$0
Co-pays	$1,040
Co-insurance	$0
Limits or exclusions	$0
Total	**$1,040**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $3,528
- **Plan pays** $3,368
- **Patient pays** $ 160

Sample care costs:

Prescriptions	$1,096
Medical Equipment and Supplies	$1,480
Office Visits and Procedures	$594
Education	$115
Laboratory tests	$165
Vaccines, other preventive	$78
Total	**$3,528**

Patient pays:

Deductibles	$0
Co-pays	$160
Co-insurance	$0
Limits or exclusions	$0
Total	**$160**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call (713) 274-5500 or toll free at (800) 279-2401 or visit us at **www.aetna.com**.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.harriscounty/tx.gov/hrrm** or call (713) 274-5500 or toll free (866) 474-7475 to request a copy.